Technical Assistance Document 2

Disorders of Attachment

A Technical Assistance Document

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services

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Purpose

To delineate standards set forth by the Arizona Department of Health Services (ADHS) for the approach to and treatment of the full continuum of Disorders of Attachment.

Target Population(s)

Children enrolled in the RBHA/TRBHA systems that require treatment for Disorders of Attachment.

Definitions

Introduction

Disorders of Attachment are conditions increasingly recognized in children and adolescents who have suffered early neglect, abuse and/or pathogenic care. Deficiencies in parental nurturing and basic care provision, inadequacies in caretaker interactions, internal processes that interfere with a child's ability to receive or benefit from parental nurturance, unavoidable breaks in parental availability or consistency, and the resulting inadequate attachment experiences can result in numerous symptom-complexes including:

- Failures to thrive,
- Separation anxiety,
- Avoidant personality disorders,
- Depressive disorders,
- Delinquency,
- Academic problems, and
- Borderline intelligence.

The time at which the deficiencies in attachment occur, the type and degree of deficiencies, and the level of security that the child experienced beforehand influence the permanency and severity of resulting symptoms. In early childhood, initial problems can present as poor eye contact, compromised abilities to seek comfort from caregivers, food rejection, and blunted emotional responses to caregivers. As children age, symptoms can vary from mild disturbances in self control, low self esteem, anger, delayed emotional development and negative attitude, to physical and emotional impairments that force children to sabotage intimacy in relationships, to more severe and persistent symptoms of Reactive Attachment Disorder. Although there is limited consensus on the prevalence of these disorders, it is clear that there is increased vulnerability in children from low socioeconomic groups and in families in which caregivers cannot respond adequately to the basic needs of their children, and that overrepresentation exists in children involved with social service agencies. Repeated changes of primary caregivers prevent the formation of stable attachments.

Recognition must therefore be given to the premise that the more a child experiences transitions and multiple placements, the greater the likelihood of attachment problems.

Treatment Priorities

Given the varying severities and conditions that present, treatment priorities must be well considered and timely. Although a thorough and comprehensive assessment is required before a treatment plan can be fully developed, services should not be delayed until assessment processes are completed. Children should be evaluated for co-occurring disorders, which if left untreated, could lead to unsuccessful resolutions to more obvious relational issues. As with all behavioral health conditions, treatment plans must be based on the distinct needs of the child, not determined by diagnosis alone.

Capacity

All RBHAs are required to maintain capacity to competently treat children presenting with any degree of symptomatology. ADHS does not require RBHAs to provide specific treatment modalities or to embrace any particular treatment philosophy or orientation. All presentations of these disorders require interventions that are individualized to the specific needs of the child and family, designed and planned with full family collaboration, and implemented with sensitivity to the family's values and treatment desires, preferably in the context of a child/family team. Requests for a specific modality from child/family team members must be given due consideration and regarded in the context of clinical appropriateness, evidence of efficacy and the likelihood of success, and cost-effectiveness.

Treatment Plans

Treatment plans must be strength-based and, to the extent possible, should draw upon natural, community-based supports. The safety of the child, the child's sense of security, and the development of long-term placement options and anticipated permanency must be considered first priorities. Through family centered approaches, primary caregivers should be taught how to nurture, how to understand the reasons for their child's behaviors before disciplinary consequences are considered, how to interact with children based on emotional, as well as chronological age, how to be consistent and predictable, how to listen and talk with their children, how to develop and maintain realistic expectations and how to teach and role model appropriate social behavior. Sensitivity to a child's placement history, sense of loss, and fears of permanency must be promoted. These goals, among others, can be approached through supportive interventions that address caregiver self-care and self-preservation, caregiver education, communication training, family or marital therapy, parent-infant, parent-toddler and parent-child groups, and home-based outreach services.

Treatment Setting

Individual treatment of the child must be provided in the least restrictive, effective setting that sustains proximity to home and natural supports. All service settings, a full array of covered services, and specialty providers as indicated must be considered. The treatment continuum must include community-based in-home services, respite, outpatient services and psychotropic medication prescribing and monitoring. Counseling interventions can include individual, group and play therapies that promote social skills, anger control, and behavioral change and management. Out-of-home placements must also be made available, but utilized only as a last resort and when other behavioral health services have been ineffective or contraindicated, or when co-existing conditions so require. When symptoms preclude a return to home and family, treatment must be supportive of and coordinated with child welfare agencies and the Juvenile Court, their collaborative efforts determining long-term, permanent placement needs. Recognition must be given to the premise that the more a child experiences transitions and multiple placements, the greater the likelihood of attachment problems**.**

Summary

It is understood that the majority of therapeutic interventions used for attachment disordered children are taken from various therapeutic frameworks such as Psychodynamics, Gestalt, Cognitive-Behavioral, Family Systems, Ericksonian, Object Relations, Attachment Theory and Therapy. There is a tendency to dismiss non-traditional approaches to treatment until results can be documented scientifically and an evidence base has been established for their use. While ADHS does not endorse protocols that rest only on anecdotal accounts, it recognizes the potential of innovative therapeutic approaches. In all cases, the safety and the child's sense of security must be assured. Therapies that cause pain or discomfort, that have the potential to result in injury or perceived abuse by the child or others, or that unnecessarily remove a child from proximity to home or natural supports are not permitted. Treatment protocols that unduly restrict a child's physical movement may endorse techniques that come uncomfortably close to physical restraints. These are specifically disallowed in settings other than Level I facilities by Office of Behavioral Health Licensure Rules (A.A.C. R9-20-602) and are likewise not permitted.